

Payment for physician services in the Medicare program

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Statement of
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Chairman Bilirakis, Congressman Brown, Members of the Subcommittee. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss payment for physician services in the Medicare program.

Medicare expenditures for physician services are the product of the number of services provided, the type of service, and the price per unit of service. The number and type of services provided we refer to as service volume. The sustainable growth rate (SGR) system was meant to control the volume of physician services and hence total expenditures for physician services by setting the update (change in unit payment for the year) for physician services. The SGR is based on changes in: the number of beneficiaries in the Medicare fee-for-service program; input prices; law and regulation; and gross domestic product (GDP). The GDP, the measure of goods and services produced in the United States, is used as a benchmark of how much growth in volume society can afford. The basic SGR mechanism is to compare actual spending to target spending and adjust the update when there is a mismatch.

The SGR approach has three basic problems.

- It disconnects payment from the cost of producing services. The formula produces updates that can be unrelated to changes in the cost of producing physician services and other factors that should inform the update. If left alone, negative updates would provide a budget control but in so doing would produce fees that in the long run could threaten beneficiaries' access.
- It is a flawed volume control mechanism. Because it is a national target, there is no incentive for individual physicians to control volume. When fee reductions have occurred

they have not consistently slowed volume growth and the volume of services and level of spending are still increasing rapidly.

- It is inequitable because it treats all physicians and regions of the country alike regardless of their individual volume influencing behavior.

The SGR formula has produced updates that in some years have been too high and in others too low. As we will discuss below, MedPAC has consistently raised concerns about the SGR—when it has set updates both above and below the change in input prices. In the Medicare Modernization Act (MMA), the Congress intervened to prevent the negative payment updates for 2004 and 2005 that would have occurred under the formula. But every time Congress acts to override a negative update, the formula automatically must lower updates in the future to make up for it. As a result, the current projection according to the trustees of the Medicare trust funds, is that annual updates of negative five percent will occur for seven consecutive years. The trustees characterize this series of updates as “unrealistically low” and in terms of budget scoring, these projections make alternatives to the SGR appear to be unrealistically expensive.

Instead of relying on a formula, MedPAC recommends a different course—one that involves explicit consideration of Medicare program objectives. Updates should be considered each year to ensure that payments for physician services are adequate to maintain Medicare beneficiaries’ access to necessary high quality care. At the same time, the growth in the volume of physician services should be addressed directly. Volume growth differs across geographic areas and by service and ultimately is the result of individual physician’s practice decisions. Is all the care being provided necessary? Dartmouth researchers and others have shown that often high quality

care is not correlated with more services. We know the private sector is taking steps to control volume in services such as imaging with very high growth rates. Volume growth must be addressed by determining its root causes and specifying policy solutions. A formula such as the SGR that attempts to control volume through global payment changes treating all services and physicians alike is bad policy and will produce inequitable results.

In this testimony we will review how the SGR came about, explain the problems with it, look at our alternative for constructing yearly updates, and provide some thoughts on addressing volume growth. We understand the budget dilemma the Congress is facing. MedPAC is sensitive to the budget context and publishes the budget implications of its recommendations in its reports to the Congress. We are aware that our proposal will, because of the way the SGR and budget scoring works, be expensive from a scoring perspective. But relative to what is likely to happen (the Congress continuing to intervene to counteract the SGR's negative updates) it would be less so. When the budget score is an artifact of a comparison with an "unrealistically low" current law baseline, it should not prevent consideration of sensible policy alternatives.

Historical concerns about physician payment

Medicare's payments for physician services are made according to a fee schedule, which includes payment rates for over 7,000 discrete services. It is designed to account for cost differences among services and geographic areas.

The Congress established the fee schedule as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA89). As a replacement for the so-called customary, prevailing, and reasonable

(CPR) payment method that existed previously, it was designed to achieve several goals. First, the fee schedule decoupled Medicare's payment rates and physicians' charges for services. This was intended to end an inflationary bias that was believed to exist under the CPR method because it gave physicians an incentive to raise their charges.

Second, the fee schedule corrected distortions in payments that had developed under the CPR method. Evidence of those distortions came from William Hsiao and his colleagues at Harvard University who found that payments were lower, relative to resource costs, for evaluation and management services but higher for invasive, imaging, and laboratory services. Further evidence came from analyses, conducted by one of MedPAC's predecessor commissions, the Physician Payment Review Commission, that revealed wide variation in CPR-method payment rates by geographic area, that could not be explained by differences in practice costs.

A third element of the OBRA89 reforms is central to our testimony today. To allow for annual updates of the fee schedule's payment rates, the legislation established a formula based on achievement of an expenditure target. This approach to payment updates was a response to rapid growth in Medicare spending for physician services. From 1980 through 1989, annual growth in spending per beneficiary, adjusted for inflation, ranged widely, from a low of 1.3 percent to a high of 15.2 percent. The average annual growth rate was 8.0 percent.

Because over half of the increase in spending in the 1980s had been due to increases in the volume of services, the process for setting an expenditure target focused on growth in the volume of services. Based on a volume performance standard (VPS), it linked annual updates of the fee

schedule's conversion factor to growth in the number and type of services physicians provide. If volume growth in a year exceeded that allowed by the VPS, the update was adjusted downward two years later.

Because of physicians' unique role in the health care system, the hope was that the VPS would give them a collective incentive to control the volume of services. Physicians order tests, imaging studies, surgery, drugs, and otherwise serve as gatekeepers of the health care system. In addition, the unit of payment in the fee schedule is quite small—the discrete service. By contrast, the unit of payment for most other sectors is larger. A large unit of payment, such as a hospital stay, gives providers more opportunities to respond to financial incentives and operate efficiently. They can economize on both the mix and quantity of services provided. They can also economize on the inputs used to produce services. A small unit of payment, such as a discrete service (e.g., an office visit), limits the reach of financial incentives to the mix and quantity of inputs.

Experience with the VPS formula showed that it had several methodological flaws that prevented it from operating as intended. For example, each year's VPS was a function of the historical trend in the rate of growth in the volume of services and progressively higher legislated deductions from those growth rates. As the result of a slowdown in the growth of the volume of services during the 1990s, the VPSs became unrealistically stringent.

The problems with the VPS formula prompted the Congress to replace it as part of the Balanced Budget Act of 1997. Under the SGR, the expenditure target is not a function of historical growth in the volume of services. Instead, the SGR target is based on growth in real GDP per capita and

other factors—inflation in physicians’ practice costs, changes in enrollment in fee-for-service Medicare, and changes in spending due to law and regulation. As noted, the real GDP factor was included in the SGR to link the expenditure target to growth in the national economy. This linkage was thought appropriate because volume growth for physician services is theoretically as unlimited as the demand for health care. This Congress decided to link to GDP as a benchmark of what the U.S. economy could afford.

The problem with the current update system

Setting prices correctly in Medicare’s payment systems is essential to maintain access to services for Medicare beneficiaries. The underlying problem with the current SGR system is that it attempts both to control total spending on physician services delivered to Medicare beneficiaries and to set prices accurately. These two goals can seldom be achieved simultaneously. If actual total spending for physician services differs from the expenditure target, to control it fees under the SGR system are adjusted upward or downward. When this occurs, payments are usually either too low, potentially jeopardizing beneficiaries' access to care, or too high, making spending higher than necessary. The SGR attempted to achieve both goals and failed, as did the Volume Performance Standard system before it.

An expenditure target approach, such as the SGR, assumes that increasing updates if overall volume is controlled, and decreasing updates if overall volume is not controlled, provides physicians nationally a collective incentive to control the volume of services. However, this assumption is incorrect because physicians do not respond to collective incentives but individual

incentives. An efficient physician who reduces volume does not realize a proportional increase in payments. If anything in the short run an individual physician has an incentive to increase volume under such a system and the sum of those individual incentives will result in an increase in volume overall and an eventual further reduction in fees. In fact, CMS makes exactly that assumption when it estimates the so-called behavioral response of physicians to lower payments—which is an increase in volume of services provided.

Over a longer period, if payments were clearly less than physicians' marginal cost of providing a service, we might see physicians cut back their Medicare practice and concentrate on other patients, devote more time to other professional or leisure activities, or leave practice altogether. Ultimately, we could see a shift in residency preferences away from those specialties most heavily dependent on Medicare. The result eventually would be decreased access for Medicare beneficiaries which could be very difficult to reverse.

Compounding the problem with the conceptual basis of the system, the SGR system has produced volatile updates. To control spending the SGR compares actual spending to an expenditure target. Experience has shown that the target can change abruptly, leading to volatility in the updates. In 2001, a reestimate of historical GDP lowered the spending target. The target then decreased even more when both actual and projected GDP went down. Updates went from increases in 2000 and 2001 of 5.4 percent and 4.5 percent, respectively, much larger than the increases in practice costs, to an unexpected large reduction in 2002 of 5.4 percent. This volatility illustrates the problem of trying to control spending with an update formula.

Despite this volatility, surveys in 2002 found that most beneficiaries were able to obtain physician care, and most physicians were willing to serve Medicare beneficiaries following the payment reduction. The CAHPS-FFS survey, sponsored by CMS, found that 90% of beneficiaries report that they “always” or “usually” got a timely appointment for routine care in the fall of 2002. A large physician survey—the National Ambulatory Medical Care Survey—found that among office-based physicians who commonly saw Medicare patients, 93% were accepting any new Medicare patients throughout 2002. Additionally, we have found that the supply of physicians furnishing services to Medicare beneficiaries has more than kept pace with the growth in the beneficiary population, through 2002. Further, in cases where we are able to analyze 2003 data, we find that access to physician care was good in 2003.

In the MMA, the Congress attempted to reduce the volatility problem. The GDP factor in the SGR is now a 10-year rolling average, which dampens the effects of yearly changes in GDP growth. However, there is another source of volatility which has not been controlled—estimating changes in enrollment in traditional fee-for-service Medicare. Here, we can anticipate reestimation of enrollment growth as CMS gains experience with shifts in enrollment from traditional Medicare to Medicare Advantage. Under the SGR, this could lead to continued volatility in spending targets and updates.

A different approach to updating payments

To address these problems, in our March 2002 report we recommended that the Congress replace the SGR system for calculating an annual update with one based on factors influencing the unit costs of efficiently providing physician services. Replacing the SGR system could allow updates

more consistent with efficiency and quality care and would also uncouple payment updates from spending control. If total spending for physician services needs to be controlled, it is necessary to look at more than just the payment update mechanism. For example, by achieving appropriate use of services through outcomes and effectiveness research, as we suggested in our March 2001 report to the Congress, and by addressing volume growth directly as discussed in the next section.

A new system should update payments for physician services based on an analysis of payment adequacy which would include the estimated change in input prices for the coming year, less an adjustment for growth in multifactor productivity. Updates would not be automatic (required in statute) but be informed by changes in beneficiaries' access to physician services, the quality of services being provided, the appropriateness of cost increases, and other factors, similar to those MedPAC takes into account when considering updates for other Medicare payment systems. Furthermore, the reality is that in any given year Medicare might need to exercise budget restraints and MedPAC's analysis would serve as one input to Congress's decision making process.

We stress that payment updates should take into account productivity improvements that enable physicians to provide care more efficiently. Productivity gains are certainly possible in physician services. For example, Pope and Burge found that doubling the size of a physician practice increases productivity with no increase in practice expense per physician. Other gains might come from new technology, economies of scale, managerial skill, and changes in how care is delivered.

A different approach to controlling volume

If payment rates are adequate and updated to account for changes in efficient physicians' cost, the remaining issue is controlling volume, which is important for both beneficiaries and taxpayers.

For beneficiaries, increases in volume lead to higher out-of-pocket costs—copayments, the Medicare Part B premium, and any premiums they pay for supplemental coverage. For taxpayers, increases in volume lead to higher Part B expenditures supported with the general revenues of the Treasury.

The concern is that volume growth has accelerated recently (Figure 1). From 2000 to 2001 volume increased 5.4 percent and from 2001 to 2002 it increased by 5.6 percent. To be clear, this is growth in volume per beneficiary and does not reflect changes in Medicare payment rates. Preliminary data suggest that relatively high volume growth continued in 2003. Regardless of the direction of the annual update, volume growth continued, it increased both when the update increased and when it decreased.

Among the effects of this growth, is an increase in the monthly Part B premium. Because it is determined by average Part B spending for aged beneficiaries, an increase in the volume of services affects the premium directly. From 1999 to 2002 the premium went up by an average of 5.8 percent per year. By contrast, cost-of-living increases for Social Security benefits averaged only 2.5 percent per year during that period. What is more, since 2002 the Part B premium has gone up faster still—by 8.7 percent in 2003 and 13.5 percent in 2004. The projected increase of 17.3 percent for 2005 is even larger.

Volume growth also has implications for the federal budget. The Committee is aware of the growth of Medicare relative to the nation's output of goods and services as discussed in the Medicare trustees report. Increases in Medicare spending per beneficiary is an important reason for that growth, cited by the Congressional Budget Office and the General Accounting Office among others.

However, some of the root causes of volume growth may be amenable to policy action and some growth may be desirable. For example, growth arising from technology that produces meaningful gains to patients, or growth where there is currently underutilization of services may be beneficial. But one indicator that not all growth is good may be its variation. Among broad categories of services, growth in volume per beneficiary ranged from about 10 percent to over 30 percent, based on our analysis of data comparing 2002 with 1999 (Figure 2). Within these broad categories, growth rates were higher for services which researchers have characterized as discretionary (e.g. , imaging and diagnostic tests). In imaging, for example, growth rates were over 15 percent a year for such services as magnetic resonance imaging, computed tomography, and nuclear medicine.

In addition, volume varies across geographic areas. As detailed in our June 2003 report to the Congress, the variation is widest for certain services, including imaging and tests. Researchers (e.g. Wennberg and Fisher) have reached several conclusions about such findings:

- Differences in volume among geographic areas is primarily due to greater use of discretionary services sensitive to the supply of physicians and hospital resources.
- On measures of quality, care is often worse in areas with high volume than in areas with lower volume. The high-volume areas tend to have a physician workforce composed of relatively high proportions of specialists and lower proportions of generalists.
- Areas with high levels of volume have slightly worse access to care on some measures.

All this suggests that volume may be too high in some geographic areas.

Addressing the volume problem

Is it possible for Medicare to address problems with the volume of services without resorting to a formula to control spending? To seek answers to this question, MedPAC has begun to consider strategies used by private insurers to purchase services. In doing so, we have focused particularly on imaging services because of the wide variation in the volume of these services, geographically, and because of the rapid growth in that volume.

What we have found is that private insurers are confronting rapid growth in use of the services and concerns such as the following:

- proliferation of imaging equipment;
- lack of familiarity with new imaging modalities among non-specialist physicians;
- self-referral, including ordering of imaging studies by physicians who furnish the studies with equipment in their offices;

- direct-to-consumer marketing of imaging services and associated questions about the need for demand management;
- defensive medicine in response to physician concerns about professional liability;
- repetition of imaging studies; and
- poor quality of imaging equipment in some settings.

In adopting their purchasing strategies, private insurers are working to control growth in the cost and utilization of imaging services while ensuring access to appropriate care.

The strategies they are adopting are multiple, depending on the insurer they can include profiling, pre-authorization, beneficiary education, privileging, coding edits, and safety standards and site inspections. One study, based on site inspections, showed facilities failing at rates approaching 50 percent, depending on the type of practitioner offering the services. Reasons for the failures included age of the equipment and use of the incorrect equipment for the types of imaging studies conducted. Coding edits are rules invoked during claims processing to decide whether and how much to pay for billed services. Medicare has a set of these edits, developed under what is known as the Correct Coding Initiative. Private insurers often use Medicare's edits but then augment them with other edits to, for example, adjust payment downward when multiple services are billed on a single claim.

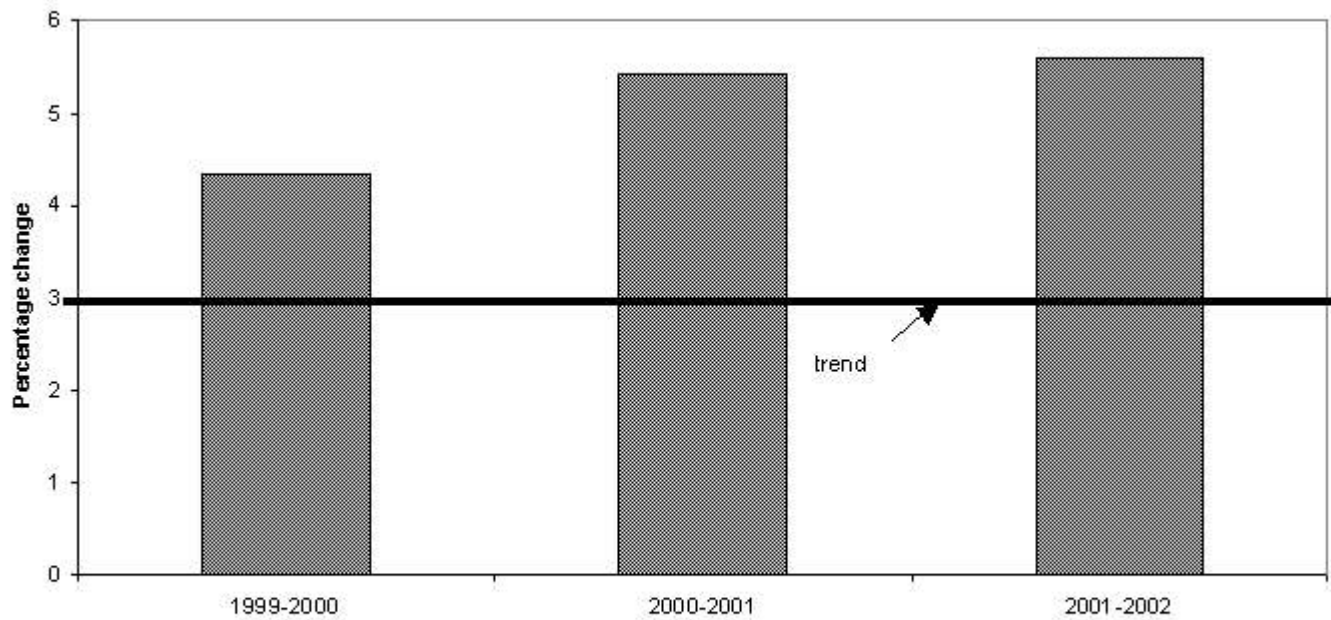
Whether Medicare should do more to emulate private insurers' strategies for purchasing imaging depends on the administrative feasibility of more closely aligning Medicare policy with the strategies of private insurers. It also depends on the effectiveness of those strategies for making

the purchasing of imaging services more efficient. MedPAC plans to address these issues during the coming year.

Our other focus is on linking Medicare payment to quality to improve quality in fee-for-service Medicare and in care for Medicare beneficiaries furnished by private plans. In our March 2004 report we recommended two sectors where the Congress can act now—rewarding quality care in outpatient dialysis and Medicare Advantage. Those two areas have the requisite measuring systems in place to begin to pay for quality. We encourage a payment-for-quality approach that is budget neutral, rewards both improvement and attainment, and varies quality measures over time.

As discussed, higher volume does not correlate with higher quality. Thus, it may be possible to increase the quality of the care beneficiaries receive and at the same time provide incentives to control the volume of services. Expanding payment for quality to the physician sector, where payment is still by the individual services provided, will be a challenge. But it is a challenge that must be met to ensure high quality care for Medicare beneficiaries within a sustainable Medicare program.

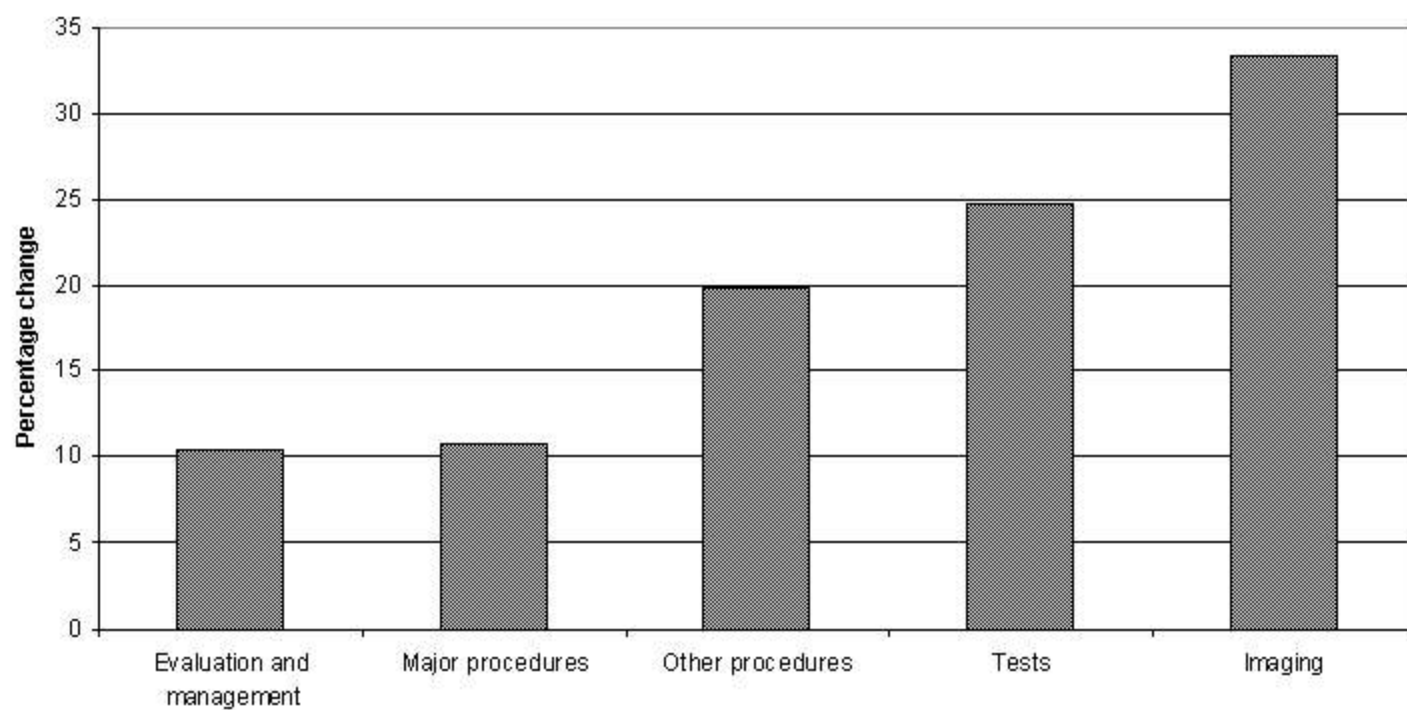
Figure 1: Growth in volume per beneficiary, all physician services



Source: MedPAC analysis of claims data for 100 percent of beneficiaries.

Note: The trend line represents the underlying trend in volume per beneficiary used by CMS actuaries to project volume for the report of the trustees of the Medicare trust funds.

Figure 2: Cumulative growth in volume per beneficiary, by type of service, 1999-2002



Source: MedPAC analysis of claims data for 100 percent of beneficiaries.